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ABSTRACT

The manual aims to assist occupational and physical therapists in describing the differences between school-based therapy and clinic-based therapy, recognizing the primary role of school-based therapy in special education, identifying the therapist's responsibilities in the Individualized Education Program development process, describing the therapist's role in delivering a full range of therapy services, and determining an appropriate distribution of the therapist's time. The manual distinguishes clinic therapy from school therapy; defines legal terms relating to school therapy; describes the responsibilities of therapists, therapist assistants, and classroom aides; discusses the therapist's role on the multidisciplinary team and in the referral process; lists services provided by therapists; outlines the range of intervention services; presents a functional approach to treatment; and suggests a formula for determining caseloads. Appendices contain sample job descriptions, excerpts from Public Law 94-142, licensing requirements in Oregon, a list of acronyms, a directory of Oregon direct service providers, and a review of "related services" requirements under Public Law 94-142. (JDD)

THE ROLE OF THE PHYSICAL THERAPIST AND THE OCCUPATIONAL THERAPIST IN THE SCHOOL SETTING

Judith Hylton, Penny Reed
Sandra Hall and Nancy Cicirello

TIES: Therapy In Educational Settings

A collaborative project conducted by Crippled Children's Division -- University Affiliated Program, the Oregon Health Sciences University and the Oregon Department of Education, Regional Services for Students with Orthopedic Impairment. Funded by the U.S. Department of Education, Office of Special Education and Rehabilitation Services, grant number G008630055.

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September 1987

In writing this manual we have chosen to avoid awkward word combinations such as (s)he and his/hers, and instead have selected to refer to children as "he," therapists, teachers and aides as "she," and supervisors as "he." We hope the reader will accept this style and find it comfortable, for that is our intent.

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We also thank the physical and occupational therapists in schools throughout Oregon who field tested these materials and offered many valuable suggestions for their improvement. We thank our fine support staff, Sharon Pearce, Dee Rauk-Besel and Jessie Taylor, for their efficiency and good humor even while typing revisions of revisions. And we thank the children in Oregon's schools who have taught us how we learn.

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PREFACE

Project TIES: Therapy in Educational Settings is a collaborative effort conducted by the Crippled Children's Division - University Affiliated Program at the Oregon Health Sciences University and the Oregon Department of Education, Regional Services for Students with Orthopedic Impairment. Project TIES was funded by the U S Department of Education, Office of Special Education and Rehabilitative Services, grant number G008630055. The goal of this three year project is to develop training materials for physical therapists and occupational therapists who work in schools with students who have a severe orthopedic impairment.

The content for these training materials was determined by therapists practicing in schools in Oregon through a series of formal and informal needs assessments. Project staff then grouped the identified needs into topical categories and determined which format - a manual or a videotape accompanied by a manual - would best convey the content of each topic. Sixteen topics were identified, eight warranting coverage through both a videotape and a manual.

The training materials were developed primarily for therapists who are new to the unique demands of the school setting or who have had little experience with children who have a severe orthopedic impairment. Other people such as administrators, teachers, aides and parents will find these materials helpful in understanding what therapists do and the rationale behind their efforts to integrate students' therapy programs into the larger context of their educational programs.

The titles of the manuals and videotapes planned for completion by May 1989 are listed below. The titles are subject to change if similar materials become available through sources outside Project TIES.

Adapting Materials and Equipment, with videotape

Adaptive Physical Education, with videotape

Augmentative Communication, with videotape

Assessing Students' Need for Therapy

Considerations for Feeding Children Who Have a Neuromuscular Disorder, with videotape

Developing and Monitoring Intervention Programs

Developing Functional IEPs

Positioning and Handling, with videotape

Promoting Acceptance of Students Who Have a Handicapping Condition, with videotape

Role of the Physical Therapist and Occupational Therapist in School Settings

Role of Teachers, Aides and Parents in Enhancing Therapy

Selected Articles on Feeding Children Who Have a Neuromuscular Disorder

Self Help Skills, with videotape

Therapists as Consultants

Training School Personnel

Tri-wall Construction, with videotape

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COMPETENCIES

Upon completing this manual, the therapist will be able to:

1. Describe the essential differences between school-based therapy and clinic-based therapy.

2. Recognize the primary role of school-based therapy in special education.

3. Identify the therapist's responsibilities in the different steps of the IEP referral process.

4. Describe the therapist's role in delivering a full range of therapy services that includes direct and indirect therapy.

5. Describe how therapy activities relate to special education.

6. Determine an appropriate distribution of the therapist's time using a formula that was devised for this purpose.

7. Demonstrate knowledge of the duties, responsibilities and qualifications of the physical therapist, occupational therapist and therapy assistant as indicated in a typical job description for each.

SCHOOL THERAPY IS DIFFERENT THAN CLINICAL THERAPY

It's different. It's just plain different. Therapy conducted in the school is not the same as therapy conducted in the clinic. Therapy differs in these two settings in terms of its intent, the role of the therapist, the size of caseloads and the type of support available to the therapist.

Clinical therapy is usually undertaken as an adjunct to medical treatment for acute and chronic conditions to ameliorate an underlying disability. The goal of clinical therapy is to improve global functioning through the use of a variety of modalities. Most students who receive therapy through the school have a lifelong chronic condition for which there is no known cure. Therefore, therapy is provided in the school to help the student access educational services and benefit from his educational program. In the school, educational goals hold a primary position while therapy goals are considered secondary and are undertaken to support the educational goals.

The intent of therapy in the school shapes a different role for the therapist. While the clinical therapist delivers intensive direct services to fewer children, the school therapist delivers a wide range of services to a greater number of children. These services cover conventional individual therapy, as well as therapy within small groups; and consultation with others in the school, the community and the student's home. The therapist may be asked to suggest activities that will be conducted by teachers and aides. Thus, the school therapist is expected to share her knowledge and skills with others by demonstrating and monitoring activities that are therapeutically appropriate.

Instead of enjoying ready access to the referring physicians and medical teams as does the clinical therapist, the school therapist is often cut off from these professionals and the availability of inservice training related to the health sciences. Further, the school therapist may be perceived by others in the school as the generic medical resource in the district and asked for advice on questions outside her realm of expertise.

The significant ways in which clinical therapy and school therapy differ from one another are summarized below.

CLINICAL THERAPY	SCHOOL THERAPY
Intent	
Therapy goals are primary.	Educational goals are primary.

CLINICAL THERAPY	SCHOOL THERAPY
To treat acute conditions	To reduce effects of chronic conditions so child can benefit from the educational program
Characteristics	
Smaller caseloads with extended therapy time	Larger caseloads with shorter time for therapy activities
Services tend to be discipline based	Services are collaborative. Much time must be given to communicating with other service providers
Focus is on developmental milestones and components of movement	Focus is on functional skills and adaptations that promote the attainment of educational objectives
Few responsibilities are delegated except to parents	More responsibilities are delegated
Clients come to the clinics to see the therapist	The therapist goes to the students who are in many different settings spread over a large geographical area
Support Available	
Ready access to medical team	Educational team and administration may not always understand the therapist's role
Inservice with other health services professionals	Inservice with education professionals
Supervision is given by an experienced professional in the discipline	Supervision is given by a professional who is not a therapist
Work with or near other therapists	Little or no access to feedback and support from other therapists
Availability of variety of adaptive equipment	Scarcity of ready-made adaptive equipment

LEGAL DEFINITIONS THAT RELATE TO SCHOOL THERAPY

Public schools have not always provided physical and occupational therapy, nor have they always served children who are handicapped. It wasn't until 1975 when the U.S. Congress passed Public Law 94-142, the Education for All Handicapped Children Act, that school districts were required by law to serve these children and to provide therapy to them so they might benefit from their education program. This law has dramatically affected children who are handicapped, and it has shaped a new role within the schools for physical and occupational therapists.

In view of PL 94-142, physical therapy and occupational therapy in school settings are considered to be related services that are provided to handicapped children so they may benefit from special education. These underlined terms are given very specific meanings by the laws that govern special education.

Related services means transportation, developmental, corrective, and other supportive services such as physical and occupational therapy, speech pathology and audiology, psychological services, recreation, medical diagnostic and evaluation services, and counseling services, and early identification and assessment of handicapping conditions as may be required to assist a handicapped child to benefit from special education.

Special education means specially designed instruction to meet the unique needs of a handicapped child. It includes instruction in the classroom, home, hospitals and institutions, and instruction in physical education.

Handicapped children means any child who because of any of the following impairments needs special education and related services.

- mental retardation
- hard of hearing
- deaf
- speech impaired
- visually handicapped
- seriously emotionally disturbed
- orthopedically impaired
- deaf-blind
- multi-handicapped
- other health impairment
- specific learning disability

Please see appendix B for a reprint of the sections of PL 94-142 that apply to physical therapy and occupational therapy in the school. Also see appendix G for a discussion of related services and medical services.

THERAPISTS, THERAPY ASSISTANTS and AIDES

In schools therapists may work not only with therapy assistants but with instructional aides as well. The therapist-therapy assistant relationship in the school and in the clinical setting is similar; the therapist delegates work, including therapy activities she deems appropriate to the assistant and supervises this work. Instructional assistants, on the other hand, usually work under the direction of a classroom teacher and give no therapy, but may be trained by the therapist in such things as positioning and handling, feeding and helping students with motor activities.

OCCUPATIONAL THERAPY

Occupational Therapists and Certified Occupational Therapy Assistants (COTAs) provide services that promote improved quality of movement and posture, fine motor functioning, visual motor functioning and independence in activities of daily living. They recommend, construct and teach others to use and maintain adaptive equipment for such activities as positioning, feeding, writing and the use of educational equipment and materials.

PHYSICAL THERAPY

Physical therapists and Licensed Physical Therapy Assistants (LPTAs) provide services that promote improved quality of movement and posture, gross motor balance, strength and coordination, functional posture, appropriate positioning and mobility. They recommend, construct and teach others to use and maintain adaptive equipment such as wheelchairs, prone boards, and other devices used for positioning and mobility.

SUPERVISION

Assistants help the therapist assess student's needs and help plan Individual Education Programs, and they implement therapy programs that have been developed under direction of their supervising therapist.

All therapy given by COTAs and LPTAs must be supervised by their respective supervising therapist. While the therapist need not observe all of the assistant's activities, she must regularly monitor these activities through at least monthly contacts. The therapist and therapy assistant must develop a plan to follow if the student's status changes rapidly or in an unexpected manner, and the therapist should, of course, be available to the assistant to answer questions and to help with problem solving. The therapist reevaluates the student at least yearly or more often if needed.

ASSIGNING RESPONSIBILITIES TO THERAPY ASSISTANTS

Therapists must use good judgement when assigning responsibilities to a

therapy assistant. Therapists should assign only those responsibilities that she judges as appropriate and safe for the child and within the ability of the assistant to perform.

QUALIFICATIONS

COTAs and LPTAs must have graduated from a program that qualifies them for an Oregon license as an occupational therapy or physical therapy assistant. Assistants, by nature of their training, are expected to be knowledgeable about handicapping conditions and the application of recommended treatment techniques. They are expected to understand the principles that govern normal development and learning.

INSTRUCTIONAL AIDES

Instructional aides are not legally qualified to give therapy. They do, however, play an important role in special education programs by carrying out motor activities and instructional programs under the direction of a classroom teacher. Although an aide's assignments are usually made by a teacher, the therapist and the teacher usually collaborate in matching motor activities with the aides ability to carry them out.

JOB DESCRIPTIONS

Sample job descriptions, similar to those used in schools, for an occupational therapist, a physical therapist, a COTA and an LPTA are in Appendix A of this manual. A comparison of the performance responsibilities for a therapist, a therapy assistant and a classroom aide follows.

THERAPIST	THERAPIST ASSISTANT	CLASSROOM AIDE
Assess student's level of functioning and need for therapy	Assist in the assessment of student's level of functioning and need for therapy.	Provides information to the therapist about the student's functioning based on observation.
Develop an Individual Educational Program (IEP) for student in the area of physical or occupational therapy and participate in IEP meetings with parents.	Assist in the development of an Individual Educational Program (IEP) for student in the area of physical or occupational therapy and participate in IEP meetings with parents at the direction of the therapist.	Do not participate.

THERAPIST	THERAPIST ASSISTANT	CLASSROOM AIDE
Develop and implement therapy programs to meet IEP goals.	Implement therapy programs to meet IEP goals.	Implement motor programs or activities that are related to therapy and are recommended by therapist or therapy assistant.
Design motor programs and teach parents, teachers, aides and other appropriate personnel to implement them.	Teach parents, teachers, aides and other appropriate personnel to implement motor programs as prescribed by the therapist.	Do not train others.
Collect and record data on therapy programs.	Same	Same
Monitor and evaluate therapy programs using observation, data and/or pre-post testing.	Monitor therapy programs using observation, data and/or pre-post testing.	Report student's performance on motor programs to therapist or therapy assistant.
Manage student behavior during therapy.	Same	Same
Work cooperatively and communicate appropriately with teaching and support staff.	Same	Same
Develop and adhere to a daily schedule.	Same	As directed by teacher
Order appropriate materials and equipment; use and maintain them.	Same	Use and maintain selected equipment
Monitor and report student performance and progress.	Same	Same

THERAPIST	THERAPY ASSISTANT	CLASSROOM AIDE
Attend staff meetings and serve on committees.	Same	As directed by teacher
Complete required reports, IEP's and other forms promptly and in an acceptable manner.	Same	As directed by teacher
Negotiate professional growth goals with supervisor.	Same	Same
Perform such other educationally related duties as assigned by the supervisor.	Same	Same

MULTIDISCIPLINARY TEAM

The primary role of the therapist and of all other special educational staff in the school is to provide services that will help children to benefit from their educational program. All of the therapist's activities contribute to this role, whether she is delivering therapy, consulting with other school staff, training and monitoring others who conduct motor activities or participating in the IEP process. Underlying all of these activities is the multidisciplinary team process.

The multidisciplinary team process was introduced into special education by PL 94-142 as a means to systematically address the diverse educational needs of children with disabilities. A typical team includes parents, teachers and the related service providers (OT, PT, and speech-language pathologist). For instance, a child who has an orthopedic impairment, mental retardation and a speech disorder clearly presents a multiplicity of needs that require the expertise of people from many disciplines. However, unless these experts work as a team and regularly exchange information, they may each see the problems in their area as paramount and de-emphasize problems in other areas, perhaps to the detriment of the child's progress.

When the multidisciplinary process is applied, the special education teacher may look to the speech and language pathologist to help the child develop the functional communication needed for other learning. The speech and language pathologist in turn may rely on the physical and occupational therapists to determine effective positioning, increase breath control and facilitate the students handling of learning materials. No single discipline has all the answers. In fact, rarely can a single discipline even ask all the necessary questions. People from different disciplines who come to trust one another's judgement, to learn from one another and to work together will be able to carry out comprehensive and coherent educational programs.

Generally the student's teacher assumes a leadership role on the multidisciplinary team. This arrangement capitalizes on her greater familiarity with the student and the school environment in which he functions and increases the possibility that IEP objectives will be well integrated into the student's day. In other words, the teacher usually guides the team in selecting or prioritizing objectives for the student's IEP.

As with any team, the multidisciplinary team is a group of people who work together to achieve a common goal: to develop and conduct appropriate Individual Educational Programs for students who have a disability. This means the multidisciplinary process operates during treatment while the IEP is being implemented as well as during assessment and the IEP meeting. In order to achieve this goal, each team member must be committed to the following:

1. Focusing team efforts on addressing the needs of students by integrating assessment information and developing IEP goals based on input from all pertinent disciplines.

2. Meeting periodically, whether formally or informally, to exchange information and keep one another abreast of changes in the student's program.

3. Demonstrating a high level of competence in one's own discipline so that contributions are valuable.

4. Demonstrating respect for the contributions from the other disciplines by actively seeking ways to incorporate their assessment data and recommendations into the IEP.

5. Consciously and continually working to educate one another in one's own discipline by welcoming questions, explaining terms and concepts in everyday language and avoiding discipline-bound jargon.

THE REFERRAL PROCESS

Before a student may receive special education and any related services such as physical or occupational therapy that are paid for by the school, certain procedures must be completed. These procedures comprise the Referral Process, and are required by PL 94-142 and by State law. Essentially the process provides a means to identify children who qualify for special education and related services, determine their needs, develop a written plan for meeting these needs, implement the plan and assess its effectiveness.

As long as school districts comply with the minimum requirements of the laws that govern them, they may develop their own procedures. Therefore, procedures tend to vary a great deal from district to district.

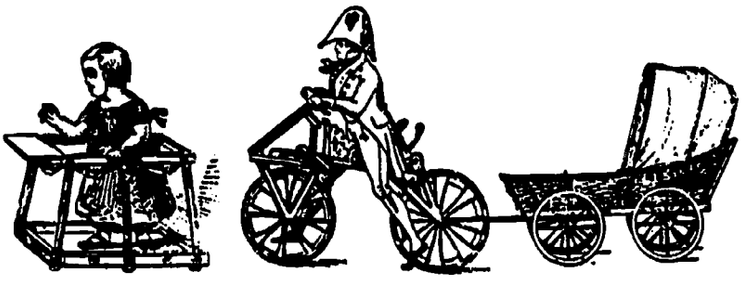
The referral process, along with the role of the physical or occupational therapist is outlined below.

REFERRAL PROCESS	THERAPIST'S ROLE
Referral	
The student is referred for assessment by a parent, teacher, or other professional.	Therapists may refer students.
Screening	
The student is screened to determine if he demonstrates any problems that should be referred for assessment.	Therapists may screen students.
Assessment	
The student is assessed by appropriate qualified professionals.	Under Oregon law a physical therapist requires a physician's prescription to assess and treat. If the referral questions or concerns relate to therapy needs, or if the assessment team identifies such needs, the student is assessed by a physical and/or occupational therapist who determines the his needs and develops recommendations for meeting those needs.

REFERRAL PROCESS	THERAPIST'S ROLE
Eligibility	
The school eligibility team reviews the assessment data and determines if the student is eligible for special education and/or related services.	The therapist may or may not serve on the eligibility team. However, her findings will be used to help determine eligibility.
Individual Education Program (IEP) Meeting	
Here, a multidisciplinary team comprised of the student's parents and the professionals who assessed him meet to synthesize their findings and develop a written plan for meeting the student's needs. The student's school placement is a part of the IEP. The IEP must be updated at least annually, or as needed.	The therapist serves as a full member of the team, reporting her findings, asking questions of others, answering questions and making recommendations for the written IEP.
Implementation	
The IEP is implemented. Special education and related services are started.	The therapist carries out the parts of the IEP that relate to her area of responsibility. She may provide direct service, monitor other adults or provide consultation as indicated in the IEP.
Assessment	
Periodic assessments are conducted to determine if the IEP is meeting the student's needs.	The therapist may conduct formal assessments, informal assessments or serve as a consultant, as appropriate.

REFERRAL PROCESS	THERAPIST'S ROLE
Assessment continued	
Each student is formally reassessed every three years to determine if he is still eligible for special education and related services. Students who no longer require therapy meet the criteria for exiting from this service. These students may, however, continue to need special education. The IEP is reviewed at least annually and updated.	The therapist conducts a formal assessment every three years to document the student's eligibility for service.

SURVIVAL KIT #1



Welcome to school. Your particular understanding of students' needs and your expertise are much needed.

Become knowledgeable about the policies and procedures of your school district as they relate to carrying out your job. Even federal laws may be complied with through a variety of different procedures.

Learn how best to access the teacher so you can discuss cases with her.

Be assertive about your professional growth and supervision needs. You know them better than anyone else does.

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SERVICES PROVIDED BY THERAPISTS IN SCHOOLS

Therapeutic intervention as applied in the school is typically divided into eleven functional areas as outlined on the following three pages. The terms used to designate these areas will be familiar to most therapists. However, the services provided in the school setting may differ somewhat from those provided in the clinical setting.

Often the student will receive intervention in more than one functional area simultaneously. For example, a student who is learning to become independent in toileting may receive services in the following functional areas:

Communication	To signal when he has to leave the room to go to the bathroom.
Functional Mobility	To ambulate from the classroom to the bathroom and back. To transfer from a walker to the toilet and back.
Environmental Adaptations	To use grab bars, an adapted bathroom stall and adapted faucet.
Self Help	To clean self, unfasten and fasten clothing and to wash and dry hands.

School therapists are constantly challenged to apply therapies that relate to the school environment. The next two pages contain descriptions of some of the services that can be provided within each of the eleven functional areas and notes about their relationship to education.

FUNCTIONAL AREA	SERVICES PROVIDED	RELATIONSHIP TO EDUCATION
Self help	Mobility and transfer skills, feeding, adaptive equipment, wheelchairs, splints, braces, artificial limbs, PT/OT. Adaptive equipment for grooming, toileting, and feeding, adaptive clothing, OT.	To permit the student to manage personal needs in the classroom and school with minimum of assistance.

FUNCTIONAL AREA	SERVICES PROVIDED	RELATIONSHIP TO EDUCATION
Functional Mobility	Equilibrium and balance reactions, transfer skills, PT/OT. Gait and pre-gait evaluation and training with or without ambulation aids, PT.	To permit the student greatest freedom of movement within the educational setting.
Environmental Adaptations	Recommend modification of school's or student's equipment, removal of architectural barriers, PT/OT.	To permit the student access to and mobility within the educational environment.
Positioning	Positioning with adaptive devices, handling methods, range of motion, skin care, splints and braces, PT/OT.	To maintain the student in the best position for learning and functional use of hands.
Neuromuscular and Musculoskeletal Systems	Muscle strength, endurance, range of motion, gross and fine motor coordination, motor planning, oral-motor control, control of muscle tone and integration of developmentally appropriate reflexes and reactions as the basis for more normal movement, PT/OT. Adaptive equipment to improve eye-hand control, OT. Musculoskeletal deformities and deviations, PT.	To enable the student to participate maximally in school activities, and remain in school a full school day. To increase speed, accuracy and strength in manipulative skills in pre-academic and academic tasks.

FUNCTIONAL AREA	SERVICES PROVIDED	RELATIONSHIP TO EDUCATION
Sensory Processing	Equilibrium and protective reactions, muscle tone, integration of touch, visual auditory, proprioceptive, and kinesthetic input, motor planning, coordination of the two sides of the body, PT/OT.	To facilitate the student's ability to process and respond to sensory and motor information as a foundation for developing gross and fine motor skills and for organizing attention and behavior. To help bridge the gap between underlying sensory processing abilities and developing higher level language and learning skills.
Adaptive Equipment	Evaluate, recommend and construct positioning devices, modify existing devices, PT/OT.	To provide the student with a stable postural base to allow him to focus attention on educational tasks.
	Provide devices to facilitate fine motor tasks, e.g., improve pencil grip, OT.	Provide the student with alternative means to accomplish functional activities such as writing, turning pages and manipulating learning materials.
Fine Motor	Evaluate and improve fine motor functions such as reach, grasp, object manipulation and dexterity, OT.	To facilitate the student's ability to manipulate classroom objects and tools such as writing implements, puzzles and art materials. To enhance participation in manual classes such as shop and home economics.

FUNCTIONAL AREA	SERVICES PROVIDED	RELATIONSHIP TO EDUCATION
Communication	Evaluate and recommend appropriate positioning of student, adaptive equipment and communication devices necessary for functional communication (in coordination with speech therapists), PT/OT.	To enable the student to communicate ideas and answers to classroom teacher and interact with parents and family.
Prevocational and Vocational Skills	General strength, sitting and standing balance and tolerance, motor coordination, adaptive equipment, PT/OT. Vocational interest and aptitude assessment and recommendations for placement, pre-vocational training, social-emotional readiness, adpative homemaking, OT.	To prepare the student for most independent life possible, including vocational placement when appropriate (supportive to educational and vocational programs).
Physiological Function	Cardiorespiratory function and fitness, muscular strengthening, PT. Body mechanics and energy conservation techniques, PT/OT.	To strengthen muscular, respiratory, and cardiovascular systems to increase endurance to remain in school for a full day.

Adapted from: "School Administrator's Guide to Physical Therapy and Occupational Therapy in California Public Schools," California Alliance of Pediatric Physical and Occupational Therapists, 40571 Ives Court, Fremont CA 94538.

THE RANGE OF INTERVENTION SERVICES

Because students present a broad array of needs and their needs change over time, schools offer a range of both special education and related services. Therapy services provided in schools are outlined below, and those that may follow screening and evaluation are presented in more detail on pages 22-27.

- Assessment
  - Screening
  - Evaluation
- Intervention
  - Direct Therapy
    - Individual
    - Group
  - Indirect Therapy
    - Consultation
      - Case
      - Colleague
      - System
    - Monitoring

Providing a range of service options is in keeping with PL 94-142 that stipulates a student must be educated in the least restrictive environment. This means that a student must receive his educational program in the most "normal" situation from which he can profit. The environment that is least restrictive differs for each child and may change with time. For example, the least restrictive environment for doing upper body strengthening exercises may be the school weight room for a student who has spina bifida and can follow directions and safety precautions. It may be an adaptive physical education class for a student who needs closer supervision, or a special education classroom for a student who is noncompliant and easily becomes overstimulated. A therapy room may be the least restrictive environment for a student from a regular classroom who must remove some of his clothing during therapy so the therapist can observe and shape his movements.

Therapy needs vary from student to student. The student who works in the weight room may need only periodic monitoring while the one in the adaptive physical education class may need the therapist to consult frequently with the teacher about his program. The student in the special education classroom may require group therapy and the one in the therapy room may need individual therapy for a period of time.

Therapy should be matched to the student's needs. Some students require both direct and indirect therapy; for example, group therapy for developing fine motor skills and consultation for adapting materials and equipment. Depending on need, therapy services may be delivered as often as two or three times a week or as infrequently as two or three times a year, and the length of each contact may vary from a few minutes to an hour. The type, frequency and length of therapy services should be altered to address a student's changing needs.

DIRECT THERAPY

Given either individually or in a small group of students, direct therapy requires a hands-on interaction between the therapist and the student. Direct therapy in the school is similar to therapy delivered in the clinical setting where the student is helped to develop or improve particular skills. However, in the school the termination of direct therapy rarely means an end to the service since the therapist is avialable to monitor the student and to consult with the school staff who work with him.

INDIRECT THERAPY

Indirect therapy - monitoring and consultation - is recommended for students whose needs require no direct therapy and can be met adequately by a person who is well trained and monitored by the therapist. Such an arrangement has many merits. First, it meets the student's needs. Second, when the aide who conducts the student's educational programs is also trained to carry out the motor programs, the student's day is less disrupted, he has to adapt to fewer adults, and the people who work with him across several areas can build a consistency into his environment. Third, an aide who is well trained may develop greater confidence and more easily learn new skills when working with other students during the same year or in subsequent years, thus increasing the pool of competence within the school. Fourth, some therapists find that they gain an even better understanding of their own discipline when they teach parts of it to other people.

CONSULTATION

Consultation can be divided into three levels: case, colleague and system. Case consultation focuses on a specific student. Here the therapist trains teachers and other staff to carry out motor activities or other intervention strategies. In colleague consultation the therapist may consult with another therapist about a student who is assigned to that therapist, provide training to staff, or recommend sources of equipment, journal articles or other resources. System consultation deals with school or district-wide issues such as planning a year-long inservice training program, making recommendations about district special education policiies and overcoming or removing architectural barriers.

Because the therapist brings a unique and much needed expertise to the school, other staff members will look to her for general information and for assistance with problem solving. Therapists may be presented with situations for which they have no ready answer and must collaborate with other staff persons in order to solve problems. For example, consider a situation in which a student ambulates with a walker and can independently manage the distance between two classrooms but requires supervision during class changes because she dawdles and takes "side trips." This situation may require assistance from the

therapist, the school psychologist or the special education teacher. When these people pool their knowledge of the student and of their respective disciplines, they can arrive at strategies that will teach the student to function more independently by moving directly and unsupervised between two classrooms within a given period of time.

MONITORING

A student may require only periodic monitoring from the therapist if his physical condition remains stable and his educational needs are being met by his learning program. Monitoring may consist of directly observing the student in different school environments, talking with his parents and school staff and conducting any needed assessments. If changes in the student's physical status or learning program indicate a need for further intervention from the therapist, then a brief period of direct therapy and/or consultation may become the method for delivery of this intervention. For instance, if a student's physical status has remained static, but a new plan calls for him to activate electric switches on a language board, he may need devices that promote the most functional range of motion in his arms.

CONCLUSION

The lines between direct service, indirect service, case consultation and monitoring are often blurred. All may occur during a single activity. For example, while monitoring an assistant who is conducting therapy activities such as positioning with a student, the therapist may work directly with the student to determine which approach is most appropriate for him. She may then consult with the assistant and teacher to explain and demonstrate this approach and to determine how the positioning techniques can best be used throughout the student's day. Thus, consultation is always a part of direct service (at the least to apprise others of what is going on with the student) and some direct service is always a part of consultation and of indirect service (using hands-on techniques to determine and demonstrate techniques that are appropriate for the student).

During any of these activities: direct therapy, indirect therapy (monitoring and consultation) and training others, it is important that all of the staff members recognize that they are participating in the multidisciplinary team process and that their common goal is to meet the education needs of children who have a disability.

The following six pages present the range of intervention services, criteria that may be used for matching services to a student's need, and the characteristic of children for whom each service may be appropriate. These criteria and characteristics represent only one way to conceptualize service delivery and may not represent your school district's policy.

DIRECT
INDIVIDUAL THERAPY: The therapist works directly with the student in a hands-on or 1:1 manner. Included in this service is the very necessary communication with educational staff, family and medical service providers and participation in developing the IEP.

GENERAL CRITERIA

A student making rapid or moderate changes (improving or declining)

A new referral who will be reassessed after a trial period

A very complex condition that requires skills from the therapist that cannot easily be taught to other staff

TYPICAL APPLICATIONS

Children birth to approximately 6 years

Student with muscular dystrophy, cerebral palsy, active juvenile arthritis, spina bifida, osteogenesis imperfecta, arthrogryposis

Student with recent head trauma or spinal cord injury, post-operative exercise needs

Student with hypotonia - "floppy baby"

Multiple involvement, i.e., hearing impairment with motor problems which interfere with signing

EXAMPLES OF SERVICE

Feeding (oral/motor), gross motor and fine motor development related to educational and functional needs

Frequent re-evaluation to document changes and revise IEP

Adaptive equipment (wheelchairs, splints)

Classroom positioning and adaptation of academic materials and environment (posture seating)

Mobility training to attain independence in school

Range of motion to prevent deformity and to promote strengthening, sensory motor or self-help skills

Train staff to help student use new skills under a variety of conditions

Training to promote gross and fine motor skills

DIRECT
GROUP THERAPY: The therapist works with a group of two to four students. Other school staff may work with the therapist to serve larger groups of students. Service includes the necessary coordination with educational staff, family and community resources, and participation in IEP development.

GENERAL CRITERIA

Student is able to function as part of a group

Student is making steady but not rapid change (usually improving)

Student has needs similar to others in the group

School staff participates in conducting group, when possible

TYPICAL APPLICATIONS

Developmental delay in students primarily 3-9 years

Student with Down's Syndrome

Student with scoliosis

Student with sensory-integrative dysfunction

Student with socio-emotional dysfunction - autistic, behavior disorder

Student with poor self-help skills

Students needing adaptations in order to perform pre-vocational skills

EXAMPLES OF SERVICE

Gross and fine motor development

Parent and staff training to carryover program throughout the student's environment

Classroom positioning and adaptation of environment (posture seating)

Strengthening, self-help and sensory motor

INDIRECT

CASE CONSULTATION: The therapist evaluates the student, observes him in the classroom and trains other staff to carry out her recommendations. The therapist then periodically consults with the staff. Consultation may include providing information and training that will enable staff to carry out motor activities and problem solving. At mid-year or at the teacher's request, the therapist will re-evaluate the student.

GENERAL CRITERIA

Student has achieved adequate skills for participation in the educational program. The motor intervention program is static.

Student is making slow and predictable progress and needs opportunity to generalize skills through daily practice.

Teachers and aides can be taught to implement the therapy objectives.

Consultation may be ongoing.

TYPICAL APPLICATIONS

Older student with cerebral palsy who has the needed adaptive equipment and has reached maximum functional level

Student with muscular dystrophy who is not changing at present

Student with spina-bifida, head injury, or spinal cord lesion who has developed adequate functional skills and requires only monitoring of these skills

Student with inactive juvenile arthritis

Student who has received direct therapy for a substantial period of time and can now benefit from remaining in the classroom

EXAMPLES OF SERVICE

Training staff in positioning and handling, and in use of adaptive equipment

Adapting academic material

Consultation with adaptive physical education staff regarding implementing program

Consultation with other therapy resources, educational staff, or medical personnel

INDIRECT

COLLEAGUE CONSULTATION: This type of consultation addresses the needs of other professionals in the educational environment. It may or may not be student specific.

GENERAL CRITERIA

Provides information to teachers, classroom assistants, speech and language pathologists, other occupational or physical therapists and parents.

Occurs in response to requests.

TYPICAL APPLICATIONS

New teacher or classroom assistant who requires training to adopt classroom activities

Therapist new to school who requires consultation

Student moves to new school where staff are unfamiliar with his needs

EXAMPLES OF SERVICES

Training staff in appropriate lifting techniques

Adopting therapy recommendations for classroom activities

INDIRECT

SYSTEM CONSULTATION: These consultation services are related to systemwide issues and require no direct involvement with students.

GENERAL CRITERIA

Provide information to administration staff, parents and representatives from community agencies regarding systemwide policies and procedures

TYPICAL APPLICATIONS

Transportation

Architectural barriers

Community resources

Inservicing: Provide information to better facilitate therapy as a "related service" such issues as the referral process, screening, assessment, evaluation, and therapy-related inservice

Administrative Services: Establish policies and procedures, supervising PT/OT programs, budget planning, screening applicants, supervising PT/OT personnel, recruitment, clinical education, PT/OT students, PTA/OTA students, forms, letters

EXAMPLES OF SERVICES

Recommendations for transportation and safety procedures: buses, ramps, wheelchairs, restraints, car seats

Analysis of and recommendations for removing architectural barriers

Recommendations for recreation, equipment, counseling

Providing inservice for:

- Administrators
- Teachers, consultants
- Physical educators
- Parents
- Bus drivers

INDIRECT

MONITORING: "Monitor" means to watch or check on a person or thing. After a therapist evaluates a student, she may monitor his progress by periodically observing him or talking with his parents or school staff whether he receives therapy related activities or not. Monitoring may include occasional hands-on interaction between the therapist and the student to assess the student's status so the therapist can update or refine her recommendations. Monitoring is usually done in conjunction with consultation.

GENERAL CRITERIA

Student no longer needs direct service but is monitored on a maintenance basis.

Student showing little or no change.

The school program is meeting the student's needs.

The staff and parents need only a few recommendations from the therapist.

TYPICAL APPLICATIONS

Older mild cerebral palsy

Mild sensory integrative dysfunction with accomodation

Mild muscle weakness with good adaptive physical education program

EXAMPLES OF SERVICE

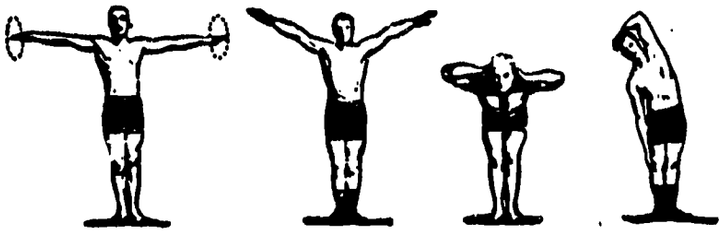
Staff training regarding disability and level of function, and signs of possible dysfunction

Parent training regarding adaptations for maximum function and home therapy program

Consultation to support personnel (especially adaptive physical education) so they can provide appropriate activities

Check on appropriate continued care i.e., keeping clinic appointments, monitoring appliances and adjusting classroom equipment

SURVIVAL KIT #2



Accept that therapy in the school must support the student's functioning in the various school environments.

Recognize the classroom teacher as the person in charge. She is in a position to decide how much time and effort will be devoted to carrying out many of your recommendations.

Support others as they carry out motor activities with students. People need your feedback in order to learn and they will probably welcome a compliment about their efforts.

Work with the educational team by giving information, ideas, enthusiasm and by encouraging contributions from others.

Before changing a student's program, observe him in the classroom and discuss planned changes with the teacher.

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DIRECT AND INDIRECT THERAPY COMPARED

Direct and indirect therapy share many common features but do differ in significant ways. In both cases, the therapist assesses the student's needs, develops educational objectives and strategies to meet these needs and, after the program has been implemented, assesses its effectiveness. During direct therapy the therapist works with the student in a hands-on manner. However, during indirect therapy the therapist works not on a one to one basis with the student but monitors his progress and consults with the teacher or aide who is carrying out the recommendations or the motor activities she has developed.

Direct Therapy via "hands on" interaction with the student	**Indirect Therapy** via monitoring and consultation
1. Assess the student to identify his areas of need, e.g., gross motor, fine motor, self-help, etc.	1. Same
2. Develop educational objectives that are based on assessment information and environmental needs of the student.	2. Same
3. Design a plan that includes teaching strategies, materials and activities for accomplishing the objectives.	3. Same
4. Implement the intervention plan. The therapist works directly with the student in a hands-on manner and may involve others in implementing the activities when appropriate. Collect data on the student's performance in order to measure progress and to use in making decisions about changing programs.	4. Plan for the generalist to implement the intervention activities. Assess the school staff's ability to implement the plan and, if necessary, train them. Periodically monitor the school staff's performance to ensure that the program is carried out appropriately and to recommend any needed changes. Monitor for the data collected by the school staff.

Direct Therapy	Indirect Therapy
	Monitor the student's progress by observing him, discussing his progress with the teacher and parents and applying hands-on assessment and treatment, as needed. Change his program as needed.
5. Assess the results of the implementation plan. Alter the program as needed.	5. Same

A FUNCTIONAL APPROACH TO TREATMENT

Clinic based therapists are adept in employing a developmental approach to treatment where they assess the child's developmental levels, design a treatment program to move him to the next developmental milestone and then deliver the treatment. While it is appropriate to the clinical setting, a developmental approach alone does not meet the demands of the educational setting because it does not prepare the student to develop the functional skills needed in the classroom. A functional approach considers the skills a student needs in the school and other environments and undertakes to help him achieve them.

GOALS Functional therapy aims to help students to benefit from their educational program by providing therapy that focuses on generalization, independence, and transition. Therapy becomes more functional for a student when he is able to generalize new skills beyond the therapy situation and apply them in a variety of everyday settings. For example: the use of a simple communication board at school to express needs becomes more functional if the board is used in all of the student's environments - at school, at home, grandmother's and camp. Functional therapy strives to provide the student with skills and adaptations that allow him to become as independent as possible in a variety of environments - the school, the home and the community. Recognizing that life is not static for even the most handicapped student, functional therapy prepares students and their parents for the inevitable transitions from one school setting to another and from high school to a post high school, vocational school and living settings. For example, before entering junior high school, a student may work on operating a combination lock for his locker, dressing down more quickly for gym and mastering a tape recorder for taking classroom notes.

PROCESS Practitioners of functional therapy view the student from a broad perspective that includes the many environments in which the child operates and the environments in which he is expected to operate in the future. The process of developing and delivering therapy that is functional involves three basic steps: assessment, planning and implementation as outlined below.

1. Assessment: Consider the student's various school, home and recreational environments and the skills needed in these environments.

   A. Review the student's records and year-end reports to determine what treatment goals and strategies have been used before and with what success. Ask yourself, "What has worked for this student and what has not?"

   B. Ask the teacher for her concerns. You might ask, "What are your concerns for this student? What is interfering with his participation in class and ability to learn?"

C. Observe the student in the classroom to determine the functional expectations that are held for him, and to identify those he can and cannot meet. Try to pinpoint why he is not meeting these functional expectations. Ask yourself if he could be more successful with environmental adaptations, better positioning, adaptive equipment, skill acquisition or altered expectations.

D. Conduct a formal assessment as appropriate. You may want to collect some baseline data against which to measure progress.

E. Discuss with the parents the student's functioning at home. Determine how the parents help him gain skills for self-help activities, activities of daily living, and participating in family recreational and work activities. Identify skills that could be used at home that will also be useful at school.

F. Consider whether the student is facing a major transition for which he needs to prepare.

2. Planning

A. In collaboration with the parents and other members of the multidisciplinary team, develop functional goals for the student's IEP. Specify motor activities and other recommendations for meeting these goals.

B. During the IEP meeting, identify who will carry out the motor activities and other recommendations that are developed by the therapist.

C. Recommend ways therapy can help the student to meet other educational goals that are developed during the meeting.

D. Identify opportunities for the student to generalize his therapy experiences to other situations and make generalization a part of his IEP.

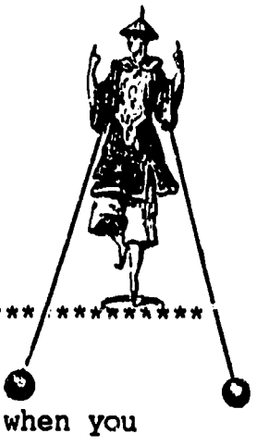
3. Implementation

A. Implement the IEP.

B. Monitor the student's progress and consult with the teacher or aide who is carrying out the motor activities and recommendations you developed.

C. Be alert for needed changes in the student's program and make them.

SURVIVAL KIT #3



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Do your part to maintain clear communications. Ask questions when you don't understand and accept questions from others as attempts to gain clarity.

Be flexible and go with the flow.

Sell therapy to educators in terms of its ability to promote educational goals. Plan your interventions around the educational needs that have been identified by the IEP team.

Don't make the teacher's job more difficult by recommending numerous time consuming and hard-to-execute interventions. Remember, your job is to develop ways that help the teacher address a student's educational needs.

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EXAMPLE OF A FORMULA FOR DETERMINING CASELOADS

Many factors determine the amount of time available for intervention and thus influence the size of caseload a therapist can manage. These factors may vary from one setting to another and over time. For example, more hours are needed at certain times for staffings and documentation; at other times more are needed for evaluations and screenings. Fine tuning of a therapist's schedule and caseload will permit maximum use of her time. Some of these factors that affect the size of a caseload are listed below:

1. Type and complexity of the handicapping conditions of students.

2. Type and amount of assessment and intervention needed.

3. Amount of time required to travel to different schools.

4. Other duties required of the therapist: record keeping, meetings, diagnostic staffings, parent education, research, etc.

5. Amount of support available from aides, assistants, and clerical personnel, and the amount of monitoring time needed from the therapists. (Allow three to five hours per week for each person the therapist monitors, depending on that person's skill level. An aide with basic training needs daily monitoring; an experienced COTA may need less direct monitoring.)

6. Number of community contacts with other agencies and physicians that are required.

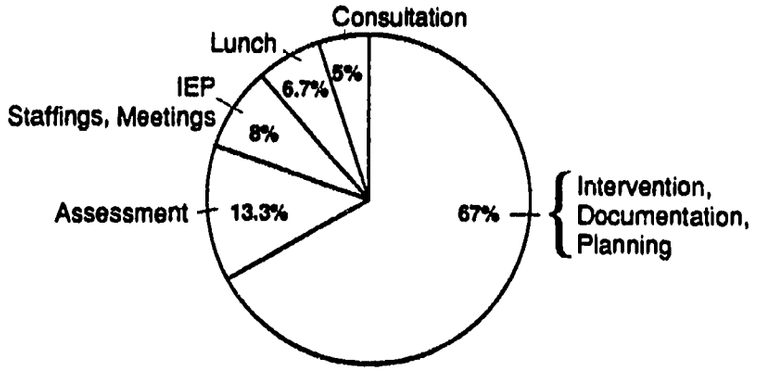
7. Type of space and equipment available.

8. Amount of inservice training required for the therapist.

A common breakdown of a therapist's week who is employed 37.5 hours a week follows.

Total working hours/week	37.5
Assessment, including documentation and information gathering	-5.0 32.5
Staffings and meetings	-3.0 29.5
Consultation	-2.0 27.5
Lunch	-2.5
Instructional Time Available	**25.0**

The remaining 25 hours available for a caseload of students, including documentation, preparation, and planning is shown graphically as follows:



You can determine the instructional time available to you by substituting figures that reflect the amount of time you spend each week on each activity. Fo. example, if you spend 5 hours per week in meetings, substitute 5 hours for the 3 in the example. If all the other times remain the same then the instructional time available to you is 23.0 hours.

The maximum number of students that can be accomodated on a therapist's caseload is influenced by the types of assessment and intervention which are needed by the students. The following service delivery pattern forms a basis for the caseload formula.

I. Assessment
    A. Screening
        1. Type I (identify from the larger population)
        2. Type II (determine need for further assessment)
    B. Evaluation
    C. Reassessment
II. Intervention
    A. Direct therapy
        1. Individual
        2. Small group
    B. Consultation
        1. Type I (Case)
        2. Type II (Colleague)
        3. Type III (System)
    C. Monitoring

A formula which considers the variables of travel time, supervision given, and type of service delivered can be applied to determine the maximum number of clients that can be served by a therapist. Documentation time (notes, reports, charts), planning and preparation are figured on a 1:4 ratio, or one hour documentation time for every four hours spent with students. Each type of intervention generally requires the following amount of time per week:

DI - Direct, individual: one student per session, ½ hour twice a week plus ¼ hour for documentation (1 hour + .25 hour = 1.25 hours per student).

DG - Direct, group: group of four students, one hour, twice a week (one-half hour per student) plus 1/8 hour documentation (.5 hour + .125 hour = .625 hour per student).

M - Monitoring: regular contact with student and/or teacher of one half hour per week plus documentation (.625 hour per student).

T - Travel between schools (actual time).

S - Supervising aides and assistants (3 to 5 hours for each person supervised).

ITA - Intervention time available.

The formula for determining amount of intervention time available uses 25 hours minus the amount of time devoted to travel and supervision.

Intervention Time Available = 25 - Travel time - Supervision time

ITA = 25 - T - S

Caseload numbers can be figured using this formula:

ITA = 1.25 DI + .625 DG + .625 M

DIRECT SERVICE ONLY

In this formula the number of hours available for intervention (ITA) equals the types of interventions (DI, DG, or M) times the time needed for each student. Therefore, a therapist who does not travel or supervise and gives only individual therapy would figure a maximum caseload as follows:

ITA = 1.25 Direct, Individual

25 = 1.25 DI

25/1.25 = DI

DI = 20

The maximum caseload for this therapist is 20 students.

MONITORING ONLY

A therapist who monitors her entire caseload and does not travel or supervise would figure her caseload as follows:

ITA = .625 Monitoring

25 = .625 M

25/.625 = M

M = 40

The maximum caseload is 40 students.

By substituting the number of intervention hours available in the formula, one can determine the appropriate number of students on a mixed caseload. Conversely, by substituting caseload numbers in the formula, one can determine the number of therapy hours required per week and the number of therapists needed for the caseload.

Example #1: An itinerant therapist travels five hours a week; one-half the intervention time is spent in monitoring and one-half in direct, individual sessions. Her intervention time available is 20 hours (ITA = 25 - T); 10 hours each for monitoring and 10 for individual sessions. Time for monitoring students equals the ITA divided by .625. Therefore, the therapist can monitor 16 students (10/.625 = 16). The number of students for individual sessions equals the intervention time available divided by 1.25 or 8 students. The therapist's maximum caseload is 24 students. For the mathematically inclined, the formula is as follows:

$\frac{1}{2}(25-T) = .625\ M$	$\frac{1}{2}(25-T) = 1.25\ DI$
$\frac{1}{2}(25-5) = .625\ M$	$\frac{1}{2}(25-5) = 1.25\ DI$
$20/2 = .625\ M$	$20/2 = 1.25\ DI$
$10 = .625\ M$	$10 = 1.25\ DI$
$10/.625 = M$	$10/1.25 = DI$
$M = 16$	$DI = 8$

This therapist can handle a maximum of 24 students.

Example #2: A therapist travels three hours a week, has a caseload of 12 for individual therapy. She has been requested to work with additional students in small groups. The therapist needs to determine how many students can be added. Intervention time available (ITA) is 22 hours (25 - T = 22). The time needed for individual students is the number of students times 1.25 or 15 hours, which leaves 7 hours available for group sessions. The number of students which can be added for group sessions equals the ITA divided by .625 or 11.2 (7/.625 = 11.2). The therapist can add 11 students for a total caseload of 23.

$$25 - T = 1.25\ DI + .625\ DG$$

$$25 - 3 = 1.25\ (12) + .625\ DG$$

$$22 = 15 + .625\ DG$$

$$22 - 15 = .625\ DG$$

$$7 = .625\ DG$$

$$DG = 7/.625$$

$$DG = 11$$

Example #3: School district XYZ has 78 students who require occupational therapy services. It is estimated that 18 need individual intervention, 32 need group sessions and 28 need monitoring. The school district needs to determine how many itinerant therapists to hire (each will travel 5 hours per week). The students who receive individual help will need 22.5 hours per week (1.25 times 18; those needing group sessions will require 20 hours (.625 times 32), and monitoring will require an additional 17.5 hours for the 28 students (.625 times 28). That is a total of 60 hours of intervention needed by occupational therapists. Each therapist will have 20 hours available (because of five hours travel), so the district needs three occupational therapists.

$$X\ (25 - T) = 1.25\ DI + .625\ DG + .625\ M$$

$$X\ (25 - 5) = 1.25\ (18) + .625\ (32) + .625\ (28)$$

$$X\ (20) = 22.5 + 20 + 17.5$$

$$X\ (20) = 60$$

$$X = 60/20$$

$$X = 3$$

Three therapists are needed for this caseload.

The following examples of caseload numbers were obtained by applying the formula. A maximum of 40 students is recommended.

Example #4: The therapist spends 50% of intervention time with students in groups and 50% in individual sessions:

No travel	30 (20 group, 10 indiv.)
2 hrs. travel/week	27 (18 group, 9 indiv.)
4 hrs. travel/week	24 (16 group, 8 indiv.)
6 hrs. travel/week	21 (14 group, 7 indiv.)

Example #5: The therapist spends 75% of intervention time with group sessions and 25% in individual sessions:

No travel	35 (30 group, 5 indiv.)
2 hrs. travel/week	32 (27 group, 5 indiv.)
4 hrs. travel/week	28 (24 group, 4 indiv.)
6 hrs. travel/week	25 (11 group, 4 indiv.)

Example #6: The therapist spends 100% of contact hours in group sessions:

No travel	40
2 hrs. travel/week	36
4 hrs. travel/week	33
6 hrs. travel/week	30

Example #7: The therapist spends 100% of contact time in individual sessions:

No travel	20
2 hrs. travel/week	18
4 hrs. travel/week	16
6 hrs. travel/week	15

The school-based itinerant occupational therapist can assume an average caseload of 20 - 40 students with a maximum of 40 students, including monitoring. If additional students will be added during the school year, it is recommended that the therapist begin the school year with less than a maximum caseload.

ITA = Intervention Time Available (25 hours per week)

T = Travel Time

S = Supervision Time

DI = Direct Individual (1.25 hours per student)

DG = Direct Group (.625 hours per student)

M = Monitoring (.625 hours per student)

	Formula	Computation
Case I		
No Travel		
No Supervisory Responsibilities		
Caseload of Individuals		
Case II		
No Travel		
No Supervisory Responsibilities		
Caseload of Monitoring		
Case III		
Travel 5 hours per week		
No Supervisory Responsibilities		
Caseload - ½ Direct Individual		
½ Monitoring		
Case IV		
Travel 3 hours per week		
Supervise 3 hours per week		
Caseload - 1/3 Individual		
1/3 Group		
1/3 Monitoring		

Adapted from "Guidelines for Occupational Therapy Services in School Systems," American Occupational Therapy Association, Inc., 198

SURVIVAL KIT #4

Develop your organizational skills. Schools have an entirely different structure than a clinic does and they lack the convenient appointment times used in the clinic.

You are therapy's best advocate. Be prepared to express clearly and completely the role of the therapist to teachers, administrators and parents.

Remember, what was true for the dinosaur is true for us too. Survival depends on our ability to adapt to change.

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APPENDICES

APPENDIX A

SAMPLE JOB DESCRIPTION
LICENSED PHYSICAL THERAPIST

Statement of Duties: Provide physical therapy services to handicapped students. These services a..e assessment, direct individual and group therapy and indirect therapy in the form of consultation and monitoring. Therapy services may include:

1. Activities that promote postural and gross motor development; e.g., head control, sitting, and standing balalnce.

2. Gait training and functional mobility for maximum independence in the educational environment.

3. Wheelchair mobility, transfer skills, and positioning.

4. Activities that improve strength and coordination, prevent deformity or enhance respiratory and cardiovascular function.

5. Evaluate adaptive equipment needs. Plan and construct adapted equipment, particularly for positioning and mobility; e.g., fitting wheelchairs, prone boards. Monitor braces and prostheses.

Supervision Received: Educational supervision will be provided by a certified educational administrator. Technical supervision will be provided by a peer (contracted from an agency, via reciprocal peer review or by a state PT/OT specialist).

Supervision Exercised: May supervise a Licensed Physical Therapy Assistant (LPTA) or an aide.

Performance Responsibilities:

1. Under a physician's prescription, assess student's level of functioning and need for therapy.

2. Provide physical therapy input to the team for developing individual education programs (IEPs) for eqch qualified student and participate in the IEP meetings with parents.

3. Under a physician's prescription, implement therapy programs to meet IEP goals.

4. Design motor programs and teach parents, teachers, aides or other appropriate personnel to implement them.

5. Collect and record data on therapy programs.

6. Monitor and evaluate the effectiveness of therapy programs using observation, data and/or pre-post testing.

7. Manage student behavior during therapy.

8. Work cooperatively and communicate appropriately with teaching and support staff.

9. Develop and adhere to a daily schedule.

10. Order appropriate materials and equipment; use and maintain them.

11. Monitor and report student performance and progress.

12. Attend staff meetings and serve on committees as directed.

13. Complete required reports, IEP's and other forms promptly and in an acceptable manner.

14. Negotiate professional growth goals with supervisor.

15. Perform other educational related duties as assigned by the supervisor.

Qualifications:

1. Knowledge of etiology, characteristics and prognosis of major handicapping conditions.

2. Knowledge of a variety of treatment techniques, and their indications and contraindications.

3. Ability to interpret physical therapy evaluations.

4. Knowledge of normal developmental sequences and learning patterns.

5. Ability to work as part of a multidisciplinary team, consult with education staff and direct a licensed physical therapy assistant, if necessary.

6. Graduation from a physical therapy school approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.

7. Must hold or be eligible for an Oregon State physical therapy assistant license.

8. Experience in a pediatric physical therapy setting is desirable.

9. Knowledge of the role of an assistant and the ability to explain that role to others.

10. Ability to present inservice training or therapy related topics to parents, teachers and other support personnel.

SAMPLE JOB DESCRIPTION

CERTIFIED OCCUPATIONAL THERAPIST

Statement of Duties: Provide occupational therapy services to handicapped students. These services are assessment, direct individual and group therapy and indirect therapy in the form of consultation and monitoring. Therapy services may include:

1. Fine motor functioning, e.g., grasp, coordination of two-handed activities.

2. Perceptual motor programs to improve motor planning, body scheme, visual and spatial perception, sequencing, and problem-solving.

3. Activities of daily living and independent living, e.g., feeding, dressing, toileting, home living skills, working, and keyboarding to enhance functional ability.

4. Monitor the use of splints and other adaptive devices designed to enhance independence in the education setting, e.g., writing, typing, feeding and positioning.

Supervision Received: Educational supervision will be provided by a certified educational administrator. Technical supervision will be provided by a peer (contracted from an agency, via reciprocal peer review or by a state PT/OT specialist).

Supervision Exercised: May supervise a Certified Occupational Therapy Assistant (COTA) or an aide.

Performance Responsibilities:

1. Assess student's level of functioning and need for therapy.

2. Provide occupational therapy input to the team for developing individual education programs (IEPs) for each qualified student and participate in the IEP meetings with parents.

3. Implement therapy programs to meet IEP goals.

4. Teach parents, teachers, aides or other appropriate personnel to implement motor programs.

5. Collect and record data on therapy programs.

6. Monitor and evaluate therapy programs using observation, data and/or pre-post testing.

7. Manage student behavior during therapy.

8. Work cooperatively and communicate appropriately with teaching and support staff.

9. Develop and adhere to a daily schedule.

10. Order appropriate materials and equipment; use and maintain them.

11. Monitor and report student performance and progress.

12. Attend staff meetings and serve on committees as directed.

13. Complete required reports, IEP's, and other forms promptly and in an acceptable manner.

14. Negotiate professional growth goals with supervisor.

15. Perform such other educationally related dutires as assigned by the supervisor.

Qualifications:

1. Knowledge of etiology, characteristics and prognosis of major handicapping conditions.

2. Knowledge of a variety of treatment techniques, and their indications and contraindications.

3. Ability to conduct and interpret occupational therapy evaluations.

4. Knowledge of normal developmental sequences and learning patterns.

5. Ability to work as part of a multidisciplinary team, consult with education staff, and direct a licensed COTA, if necessary.

6. Graduation from an occupational therapy school approved by the AMA and the American Occupational Therapy Association.

7. Hold or be eligible for an Oregon State Occupational Therapy license.

8. Experience in a pediatric occupational therapy setting is desirable.

9. Knowledge of the role of an occupational therapist and the ability to explain that role to others.

10. Ability to present inservice training on therapy related topics to parents, teachers and other support personnel.

SAMPLE JOB DESCRIPTION
PHYSICAL THERAPY ASSISTANT

Statement of Duties: Provide occupational therapy services to handicapped students. These services are assessment, direct individual and group therapy and indirect therapy in the form of consultation and monitoring. Therapy services may include:

1. Fine motor functioning, e.g., grasp, coordination of two-handed activities.

2. Perceptual motor programs to improve motor planning, body scheme, visual and spatial perception, sequencing, and problem-solving.

3. Activities of daily living and independent living, e.g., feeding, dressing, toileting, home living skills, working, and keyboarding to enhance functional ability.

4. Monitor the use of splints and other adaptive devices designed to enhance independence in the education setting, e.g., writing, typing, feeding and positioning.

Supervision Received: Educational supervision to be provided by a certified educational administrator and clinical supervision by a Licensed Physical Therapist (LPT)

Performance Responsibilities:

1. Assist in assessing students' level of functioning and need for therapy.

2. Assist in developing an Individual Educational Programs (IEP) for each student and participate in IEP meetings with parents at the direction of the LPT.

3. Implement therapy programs to meet IEP goals.

4. Teach parents, teachers or aides and other appropriate personnel to implement motor programs as prescribed by the LPT.

5. Collect and record data on therapy programs.

6. Monitor therapy programs using observation, data and/or pre-post testing.

7. Manage student behavior during therapy.

8. Work cooperatively and communicate appropriately with teaching and support staff.

9. Develop and adhere to a daily schedule.

10. Order appropriate materials and equipment; use and maintain them.

11. Monitor and report student performance and progress.

12. Attend staff meetings and serve on committees as directed.

13. Complete required reports, IEP's, and other forms promptly and in an acceptable manner.

14. Negotiate professional growth goals with supervisor.

15. Perform such other educationally related duties as assigned by the supervisor.

Qualifications:

1. Knowledge of etiology, characteristics and prognosis of major handicapping conditions.

2. Knowledge of a variety of treatment techniques, and their indications and contraindications.

3. Ability to interpret physical therapy evaluation reports.

4. Knowledge of normal developmental sequences and learning patterns.

5. Ability to work as part of a multidisciplinary team.

6. Graduation from a physical therapy assistant school approved by the Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association.

7. Must hold or be eligible for an Oregon State physical therapy assistant license.

8. Experience in a pediatric physical therapy assistant setting is desirable.

9. Knowledge of the role of an assistant and the ability to explain that role to others.

SAMPLE JOB DESCRIPTION
OCCUPATIONAL THERAPY ASSISTANT

Statement of Duties: Provide occupational therapy services to handicapped students. These services are assessment, direct individual and group therapy and indirect therapy in the form of consultation and monitoring. Therapy services may include:

1. Fine motor functioning, e.g., grasp, coordination of two-handed activities.
2. Perceptual motor programs to improve motor planning, body scheme, visual and spatial perception, sequencing, and problem-solving.
3. Activities of daily living and independent living, e.g., feeding, dressing, toileting, home living skills, working, and keyboarding to enhance functional ability.
4. Monitor the use of splints and other adaptive devices designed to enhance independence in the education setting, e.g., writing, typing, feeding and positioning.

Supervision Received: Educational supervision to be provided by a certified educational administrator and clinical supervision by a Certified Occupational Therapist.

Performance Responsibilities:

1. Assist in assessing student's level of functioning and need for therapy.
2. Assist in developing an Individual Educational Program (IEP for each qualified student and participate in IEP meeting with parents, at the direction of the OTR.
3. Implement therapy programs to meet IEP goals.
4. Teach parents, teachers or aides and other appropriate personnel to implement motor programs as prescribed by the OTR.
5. Collect and record data on therapy programs.
6. Monitor therapy programs using observation, data and/or pre-post testing.
7. Manage student behavior during therapy.

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8. Work cooperatively and communicate appropriately with teaching and support staff.

9. Develop and adhere to a daily schedule.

10. Order appropriate materials and equipment; use and maintain them.

11. Monitor and report student performance and progress.

12. Attend staff meetings and serve on committees as directed.

13. Complete required reports, IEP's, and other forms promptly and in an acceptable manner.

14. Negotiate professional growth goals with supervisor.

15. Perform such other educationally related dutires as assigned by the supervisor.

Qualifications:

1. Knowledge of etiology, characteristics and prognosis of major handicapping conditions.

2. Knowledge of a variety of treatment techniques, and their indications and contraindications.

3. Ability to conduct and interpret occupational therapy evaluations.

4. Knowledge of normal developmental sequences and learning patterns.

5. Ability to work as part of a multidisciplinary team, consult with education staff, and direct a licensed COTA, if necessary.

6. Graduation from an occupational therapy school approved by the AMA and the American Occupational Therapy Association.

7. Hold or be eligible for an Oregon State Occupational Therapy license.

8. Experience in a pediatric occupational therapy setting is desirable.

9. Knowledge of the role of an occupational therapist and the ability to explain that role to others.

APPENDIX B

EXCERPTS FROM PL 94-142

Occupational and physical therapy services as part of public school education are governed by Part B of the Education of All Handicapped Children Act of 1975, Public Law 94-142. The intent of the law is expressed in its statement of purpose: "It is the purpose of this Act to assure that all handicapped children have available to them, within the time periods specified, a free and appropriate public education which emphasizes special education and related services designed to meet their unique needs." (P.L. 94-142, 1975, Sec. 3, c.)

Legal Definitions -- Federal Code.

1. Handicapped - "The term 'handicapped children' means mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, or other health impaired children, or children with specific learning disabilities, who by reason thereof require special education and related services." (emphasis supplied) [20 U.S.C. 1401(1)].

   The implementing regulation, 34 C.F.R. 8, further defines "handicapped children": "As used in this part, the term 'handicapped children' mean those children evaluated in accordance with Regs. 300.530-300.534 as being mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, deaf-blind, multi-handicapped, or as having specific learning disabilities, who because of those impairments need special education and related services."

2. Special Education - "The term 'special education' means specially designed instruction, at no cost to parents or guardians, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions." (emphasis supplied)

3. Related Services - The term "related services" is defined at 20 U.S.C. 1401(17): "The term 'related services' means transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapping conditions in children." (emphasis supplied)

An awareness of these definitions is crucial to understanding a child's entitlement of physical and occupational therapy under the laws governing special education programs. As the United States Department of Education specifically noted in its comment immediately following the definition of special education found at 34 C.F.R. 300.14:

> "Comment. (1) The definition of 'special education' is a particularly important one under these regulations; since a child is not handicapped unless he or she needs special education. (See the definition of 'handicapped children' in section 300.5.) The definition of 'related services' (section 300.13) also depends on this definition, since a related service must be necessary for a child to benefit from special education. Therefore, if a child does not need special education, there can be no 'related services,' and the child (because not 'handicapped') is not covered under the Act."
> (emphasis supplied)

Under the law, children are not considered to be handicapped unless they actually need specially designed instruction or are found to have a physical, mental, etc., disability which adversely affects their ability to learn. Supportive services such as physical and occupational therapy are "related services," not specially designed instruction. Federal law specifically provides that "related services" are to be provided to those children defined as "handicapped" under the law when such related services are required for the child in question to benefit from the child's program of specially designed instruction.

Even when a child is handicapped (because the child needs specially designed instruction), the child does not automatically receive related services. Rather, the child is entitled to receive such related services as are required for the child to benefit from the program of specially designed instruction. Physical and occupational therapy services covered under P.L. 94-142 are only those services which enable the child to benefit from special education.

The term "related services" means transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapping conditions in children. [20 U.S.C. 1401(17)]

If it is determined through assessment/evaluation that the child is eligible for education related physical or occupational therapy services, the IEP should note that physical and/or occupational therapy is the related services to be provided. Implementation strategies such as Neurodevelopmental Treatment or sensory integration therapy are NOT identified as related services and should NOT be listed as such. The

methods of implementation are to be determined by the provider of that service and may be reflected in the goals and objectives of the IEP. (Education Due Process Reporter, 1981)

The IEP goals and objectives for physical and occupational therapy should be directed to the identified educational needs of the student and should be stated in such a way that they reflect that relationship, i.e., how will physical and occupational therapy assist the student to benefit from his special education program. Documentation of the complete process is essential and should be written in a format/language that is compatible with other educational documents.

Those students not identified as having exceptional educational needs as well as those students identified as having exceptional educational needs but who do not require physical and occupational therapy to benefit from their program of specially designed instruction are not eligible for related services.

Some examples of children who are not eligible to receive therapy as a related service are:

1. Students with a temporary disability such as a fractured leg, muscle injury, etc.

2. Students with a disability or a handicapping condition which does not require the provision of specially designed instruction. Examples of disabilities which may or may not constitute hanicapping conditions are clumsiness, scoliosis, traumatic injury to nerves/muscle of the hand, mild cerebral palsy, etc.

3. An amputee who is independent in the use of his or her prosthesis.

4. Any child who has reached maximum benefit from the therapy such that direct therapy, monitoring and consultation is no longer needed.

"'Nothing in the Act or the regulations prohibits the use of Site, local, Federal, and private sources of support, including insurance proceeds, to pay for services that may be provided to a child....' (300.111 [d] [1]), as long as the parents are not changed." (From FOCUS, A Review of Special Education and the Law, Volume 2, Number 4, September, 1982)

APPENDIX C

OREGON REVISED STATUTES

OCCUPATIONAL THERAPY

"Occupational therapy" means the analysis and use of purposeful activity with individuals who are limited by physical injury or illness, developmental or learning disabilities, psychosocial dysfunctions or the aging process in order to maximize independence, prevent disability and maintain health. The practice of occupational therapy encompassees evaluation, treatment and consultation. Specific occupational therapy services includes but is not limited to: Activities of daily living (ADL); perceptual motor and sensory integrated activity; development of work and leisure skills; the design, fabrication or application of selected orthotics or prosthetic devices; the use of specifically designed crafts; guidance in the selection and use of adaptive equipment; exercises to enhance functional performance; prevocational evaluation and training; performing and interpreting manual muscle and range of motion tests; and appraisal and adaptation of environments for the handicapped. The services are provided individually, in groups, or through social systems.

"Occupational Therapy assistant" means a person licensed to assist in the practice of occupational therapy under the supervision of, or with the consultation of, an occupational therapist.

Qualifications for licensing occupational therapist. (1) Except as provided in subsection (2) of this section or in ORS 675.270, each applicant for licensure under ORS 675.210 to 675.340 as an occupational therapist shall:

(a) Have successfully completed an educational program in occupational therapy recognized by the board, with concentration in biological or physical science, psychology and sociology, and with education in selected manual skills.

(b) Pass to the satisfaction of the board an examination conducted or adopted by the board to determine the fitness of the applicant for practice as an occupational therapist or be entitled to be licensed as provided in ORS 675.270.

(c) Have successfully completed at least six months of supervised field work that complies with rules adopted by the board.

Qualifications for licensing as occupational therapy assistant. Except as provided in ORS 675.270, an applicant for licensure under ORS 675.210 to 675.340 as an occupational therapy assistant shall:

(1) Be at least 18 years of age.

(2) Have successfully completed the academic requirements of an educational program for occupational therapy assistants recognized by the board.

(3) Pass an examination conducted or approved by the board to determine the fitness of the applicant for practice as an occupational therapy assistant.

(4) Have successfully completed at least two months of supervised field work that complies with rules adopted by the board. [1977 c.858 §6; 1981 c.250 §4]

Definitions

"Supervision". as it is used in ORS 675.210(4). means ongoing direction and instruction to establish and maintain an occupational therapy program service combined with observations and evaluation of performance of the occupational therapy assistant's services without the necessity of the occupational therapist being physically present at all times when services are being conducted.

"Consultation". as it is used in ORS 675.210(4). means conferences between the occupational therapy assistant and occupational therapist at least on a monthly basis to implement, discuss and observe patient activity and maintenance programs.

Contact the Occupational Therapy Licensing Board for further information about laws governing the practice of occupational therapy.

Occupational Therapy Licensing Board
908 State Office Building
1400 SW 5th Avenue
Portland, Oregon 97201

Peggy Smith
Executive Secretary
229-5139

APPENDIX D

OREGON REVISED STATUTES

PHYSICAL THERAPY

"Physical therapy" means treatment of a human being by the use of exercise, massage, heat or cold, air, light, water, electricity or sound for the purpose of correcting or alleviating any physical or mental condition or preventing the development of any physical or mental disability, or the performance of tests as an aid to the diagnosis or treatment of a human being. Physical therapy shall not include radiology or electro-surguery.

"Licensed physical therapist" means a professional physical therapist licensed as provided in ORS 688.010 to 688.220.

"Physical therapist assistant" means a person who assists a licensed physical therapist in the administration of physical therapy. [1959 c.461 §1; 1965 c.314 §1; 1969 c.339 §1; 1971 c.585 §1; 1975 c.111 §1]

License required to practice physical therapy or use designation. (1) Unless a person is a licensed physical therapist or holds a permit issued under ORS 688.110, a person shall not:

(a) Practice physical therapy; or

(b) Use in connection with the name of the person the words or letters, "P.T.", "R.P.T.", "L.P.T.", "physical therapist", "physiotherapist" or any other letters, words, abbreviations or insignia indicating that the person is a physical therapist, or purports to be a physical therapist.

(2) Unless a person holds a license as a physical therapist assistant, a person shall not:

(a) Practice as a physical therapist assistant; or

(b) Use in connection with the name of the person the words or letters, "L.P.T.A.", "P.T.A.", "physical therapist assistant", "licensed physical therapist assistant", or any other letters, words, abbreviations or insignia indicating that the person is a physical therapist assistant or purports to be a physical therapist assistant. [1959 c.461 §2; 1965 c.314 §2; 1969 c.339 §2; 1971 c.585 §2; 1975 c.111 §2]

Licensing procedure. Any person desiring to be a licensed physical therapist or physical therapist assistant shall apply in writing to the board, upon such form and in such manner as shall be provided by the board. Each application shall include or be accompanied by evidence, under oath or affirmation and satisfactory to the board, that the applicant possess the qualifications prescribed by ORS 688.050 (1) to (3) for applicants for licensing as a physical therapist and ORS 688.055 for applicants for licensing as a physical therapist assistant. [1959 c.461 §6; 1969 c.399 §3; 1971 c585 §3; 1975 c.111 §4]

Qualifications of physical therapist; examination. Each applicant for licensing under ORS 688.010 to 688.220 as physical therapist shall:

(1) Be at least 18 years of age.

(2) Be of good moral character.

(3) Be a graduate of a school of physical therapy approved by the board.

(4) Pass to the satisfaction of the board an examination conducted by the board to determine the fitness of the applicant for licensing as a physical therapist, or be entitled to be licensed as provided in ORS 688.060.[1959 c.461 §5; 1971 c.585 §4; 1973 c.827 §73]

Qualifications of physical therapist assistant; examination. An applicant for a license under ORS 688.010 to 688.220 as a physical therapist assistant shall:

(1) Be at least 18 years of age.

(2) Be of good moral character.

(3) Have completed to the satisfaction of the board a course for physical therapist assistants approved by the board.

(4) Pass to the satisfaction of the board an examination conducted by the board to determine the fitness of the applicant for practice as a physical therapist assistant, or be entitled to be licensed as provided in ORS 688.080.[1969 c.339 §5; 1971 c.585 §5; 1973 c.827 §74; 1975 c.111 §5]

Temporary Permit. The Board, in its discretion, may issue without examination a Temporary Permit to a person to practice physical therapy or as a physical therapy assistant in this State if the person files an application for a license by examination as provided in Section 10-015 or by endorsement as provided in Section 10-020 or 10-025 and pays to the Board at the time of filing of such application the nonrefundable filing fee set forth in Section 10-015 (2), 10-020 (1), and 10-025 (1)

as the case may be, and provides written proof that such person has graduated from an approved school and will be working under the direction of a Licensed Physical Therapist. A person holding a Temporary Permit may practice physical therapy only under the direction of a Licensed Physical Therapist. Temporary Permits may be granted to endorsement candidates, pending receipt of examination scores, reported from the Interstate Reporting Service, provided all other application materials have been received by the Board Executive Secretary. Candidates for Oregon State Licensure by examination, who file a completed application form may be granted a temporary permit until the results of the next regularly scheduled examination are available to the Board, who shall determine whether a permanent license shall be issued. A temporary permit shall not be issued to a previously unlicensed person who has failed any examination required under these rules or who has failed a similar examination in another state. Temporary Permits shall be granted for a period of not to exceed three (3) months and may be renewed by the Board at its discretion for an additional three (3) months, but no longer.

Physical Therapy Licensing Board
1011 State Office Building
1400 SW 5th Avenue
Portland, Oregon 97201

Lynn Chase
Executive Secretary
229-5043

APPENDIX E

ACRONYMS USED IN SPECIAL EDUCATION

APE	Adaptive Physical Education
CCD	Crippled Children's Division
COTA	Certified Occupational Therapy Assistant
CSD	Children Services Division
DD	Developmentally Delayed (or) Developmentally Disabled
DRAC	District and Regional Assessment Center Education, administered by Portland Public School District
ESD	Educational Service District (such as the Lane County Educational Service District, most counties have an ESD)
IEP	Individual Educational Plan
IFP	Individual Family Plan
IPP	Individual Pupil Plan
LD	Learning Disabled
LEA	Local Education Agency (or district such as the Salem Public School District)
LPTA	Licensed Physical Therapy Assistant
MDT	Multidisciplinary Team
MR	Mental Retardation (or) Mentally Retarded
MR/DD	Mental Retardation/Developmental Disabilities
NDT	Neurodevelopmental Treatment
ODE	Oregon Department of Education
OT	Occupational Therapist (or) Occupational Therapy
PT	Physical Therapist (or) Physical Therapy
ROM	Range of Motion
RSOI	Regional Services for Students with Orthopedic Impairments

SEA State Education Agency (such as the Oregon Department of Education)

SED Severely Emotionally Disturbed

S/LP Speech/Language Pathologist

SOI Severely Orthopedically Impaired

APPENDIX F

DIRECTORY OF DIRECT SERVICE PROVIDERS

Crippled Children's Division (CCD)

Regional Services Center
(Eugene) Clinical Services Building
901 E. 18th
Eugene, Oregon 97340

686-3575
1-800-637-0700

P.O. Box 574
(Portland) 707 SW Gaines
Portland, Oregon 97207

225-8095
1-800-452-3563

District and Regional Assessment Center (DRAC)

4620 SE Powell Boulevard
Portland, Oregon 97206

280-5757

Emanual Hospital and Health Center

Child Development Program
2801 N. Gantenbein Avenue
Portland, Oregon 97227

280-4505

Holladay Center

2600 SE 71st
Portland, Oregon 972:4

777-4505

Rehabilitation Insti*ute of Oregon

Good Samaritin Hospital and Medical Center
1040 NW 23rd
Portland, Oregon 97210

229-7311

Shriners Hospital for Crippled Children

3101 SW Sam Jackson Park Road
Portland, Oregor 97207

241-5090

APPENDIX G

RELATED SERVICES AND MEDICAL SERVICES REQUIREMENTS UNDER CURRENT LEGAL STANDARDS

Problems in the delivery of "related services" under P.L. 94-142 continue as a major factor in educating handicapped children. Much recent publicity has focused on the attempt in California to reduce the provision of occupational therapy in separate programs, and the litigation which ultimately resulted in a requirement that catheterization be provided a child with spina bifida to enable her to attend her regular school classroom. (Reference: #1) These publicised instances represent, to use the cliche, just the tip of the iceberg. The provision of related services by public educational agencies everywhere scattered, haphazard, and problematic.

There is also general agreement among educational administrators as to why this is the case. Many of the federally defined "related services" have traditionally been available from community service delivery systems other than the schools. School staff have rarely been qualified or trained to deliver such services. The problems of interagency coordination have too often been compounded in many states by the withdrawal of other state agencies from providing these -- given that educational agencies are presumed to have primary responsibility under comprehensive special education statutes (whether P.L. 94-142 or similar state legislation). Related service requirements thus involve the schools in novel areas of activity and relationships. Finally, such services inevitably are costly, putting pressure on local school budgets which has been only partially alleviated by federal and state reimbursements or supplements.

It is not surprising that educators have tried to protect their limited resources by searching for the appropriate limits upon related services. This course generally seeks to define various related services as not being related at all -- that is, to assert that a particular service is not of "educational" significance, but rather arises from conditions which are not "educationally" related. Primary variants of this argument are the assertions that particular services are "medical" or "health" related, involve "life supports," or arise from "emotional," "family," or "social," rather than "educational" needs.

The following comments are intended as a review of the basic legal history which has resulted in current related services requirements at the federal level. The extent of, and the limits upon, related services has been the subject of critical judicial decisions.

I. Public Law 94-142

The related services requirements of P.L. 94-142 and its regulations are familiar. As a general matter:

"The term 'related services' means transportation, and such developmental, corrective, and other supportive services . . as may be required to assist a handicapped child to benefit from special education . . ." [P.L. 94-142, Section 602 (171)].

The regulations list many specifically required services, such as:

". . . speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes . . . school health services, social work services in schools, and parent counseling and training." (P.L. 94-142 regulations, 34 C.F.R. 300.13).

Moreover:

"The list of related services is not exhaustive and may include other developmental, corrective or supportive services . . . if they are required to assist a handicapped child to benefit from special education." (300.13, Comment, emphasis added).

These are intentionally broad requirements. Realistically there are only two limitations upon their scope:

1. if a service is not "required to assist a handicapped child to benefit from special education," and,

2. if, although a service is required in such a way, it is also a "medical" service for other than diagnostic or evaluation purposes.

II. To Benefit from Special Education Only?

Many handicapped children, and particularly those with physical handicaps, may require supplemental services but in every other respect may participate in the regular course of instruction. That is, they may not need "special education" (defined in P.L. 94-142 as "specially designed instruction . . . to meet the unique the needs of a handicapped child" [Section 602 (16)], but might need a service such as catheterization or mobility assistance in order to remain in the regular classroom.

Stringing these provisions together literally, some educational officials have questioned their responsibility to provide supplemental services to such handicapped children, given the lack of relationship to "special education." Current legal requirements emphatically reject this attempt to limit service provision.

The federal courts have emphasized that handicapped children must be afforded the opportunity to attend school, and to suffer no exclusion from school solely because of their handicap. Secondly, handicapped children should be educated in the "least restrictive environment" (LRE) -- that is, to the maximum extent appropriate with nonhandicapped children, and in the regular classroom whenever possible. These more fundamental principles supercede any technical interpretations which might be discovered in the definitional nuances of P.L. 94-142.

The federal courts have already considered these particular situations. Handicapped children, who require assistance such as catheterization, but who otherwise would attend the regular classroom (with no "special" education) must be provided those services. One court found that such services were directly required by both Section 504 and P.L. 94-142 to conform to the least restrictive provisions, and because failure to provide such services would amount to the illegal exclusion of the child from school. (Reference: #2)

More recently, a federal court of appeals confirmed that catheterization in such circumstances falls

> "within a literal interpretation of the . . . (P.L. 94-142) . . definition of related services. Quite simply but, without the provision of . . . (catheterization, the child) . . . cannot be present in the classroom at all." (Reference: #1)

III. Related to "Educational" Needs

It is apparent, therefore that the courts will require delivery of services related to educational (whether "regular" or "special") needs of handicapped children. This linkage to "education" has often developed into consideration of just what the term education should encompass.

Traditionally, public schools have focused upon academic subjects and skills -- those related to mental development or cognition. In conformity to this tradition, many educators would suggest that many of the presumed "related services" are in fact not required for educational purposes at all. Physical therapy is more properly "developmental" assistance, with no relation to academic achievement. Catheterization is in the nature of a "life support," and mental health services deal with emotional or social adjustment, not education.

The most notable impact of judicial developments is the expansion of the term "education" to encompass areas such as these which are important to handicapped children. Many of the basic skills which come easily to nonhandicapped -- walking, talking, basic self-care -- may represent a high level of achievement for some handicapped children. Thus the federal courts have emphasized that "education" for handicapped children may be directed at achieving "self-sufficiency . .

[or] . . . some degree of self-care." (Reference: #4)

As summarized by one commentator:

". . . education is concerned with much more than simply the 'three R's': the definition would include instruction to teach one to dress oneself, toilet training, eating skills, and other self-help skills." (Reference: #5)

Similarly, what may be "related" to this broad objective is defined expansively. Services are related whenever:

(a) "required to assist a handicapped child to benefit from special education" [P.L. 94-142, Section 602 (17)];
(b) required to meet the needs of handicapped children as adequately as the nonhandicapped [504 regulations, 34 C.F.R. 104.33 (b)];
(c) required to enable the handicapped child to be in a regular educational environment (34 C.F.R. 104.34);
(d) a service "arises from," or has a "connection to," the effort to educate or to equal educational opportunity (Reference: #1A); or;
(e) the service might be seen as a "prerequisite" to learning. (Reference: #6).

The net result is that the federal laws, expanded by federal court decisions, have adopted broad definitions of both "education" and "relatedness." In this context, the effort to find substantial limits upon the extent of related services runs counter to most legal precedent.

IV. Judicial Responses to Specific Services

The strength of this legal precedent is manifest as one considers the more common related services in detail. Consider the requirements for the delivery of the following specific services:

(1) Occupational Therapy.

Occupational therapy is specifically listed in the P.L. 94-142 regulations (300.13), a status given some confirmation in a recent judicial decree. (Reference: #7)

(2) Physical Therapy.

Physical therapy, like occupational therapy, is listed in the P.L. 94-142 regulations (300.13), and included in the recent consent decree. (Reference: #7)

(3) Catheterization.

Thought by many to represent a service on the boundary of related

services because of obvious "medical" aspects and "life support" characteristics, catheterization has been clearly designated a related service by the courts. (Reference: #1,2)

(4) Mental Health Services -- Psychotherapy or Psychological Counseling.

It is extremely difficult ever to state categorically that mental health services are not required for "social" or "emotional" reasons. But it is equally true that emotional problems will inevitably affect the educational progress of a child. Whatever their cause, the effects of emotional problems will generally simultaneously be "educational," and "social," and "emotional." A broad concept of education virtually guarantees that emotional or psychological needs will generate educational aspects.

And in fact this has been the basic judicial response when confronted with the issue. In one recent decision (Reference: #8), a multiply-handicapped child (with epilepsy, an emotional distrubance, and a learning disability) sought placement in a residential facility. That facility would simultaneously provide medical supervision, psychological support and special education. The court decided that "all of these needs are so intemately intertwined that realistically it is not possible . . . to perform the Solomon-like task of separating them." (Reference #8) The local educational agency was required to pay for all of the services. Another court in a similar situation (Reference: #9) simply decided that "psychological" services were specifically listed within P.L. 94-142 [Section 602 (17)] and held the local educational agency fully responsible for their cost.

This simple summary of present legal interpretations of related services is that the most common areas of dispute have already been considered in the courts, and the concept of related services has not been limited in any significant way.

V. "Medical" Services Limited?

P.L. 94-142 will not require a "medical" service (unless for diagnostic or evaluation purposes), even if that service is in other respects related to educational needs. At first glance, this appears to create a major limitation upon the extent of related services requirements.

Many educational officials have argued that the specific services described above (occupational therapy, physical therapy, catheterization, mental health services), as well as others, such as the treatment of learning disabilities in a clinic, or administration of drugs by school nurses, should properly be considered "medical" in nature. By common experience and understanding, such services are frequently delivered by "medical" staff (therapists, nurses, doctors . . .), in medical settings (clinics, hospitals . . .) or with medical equipment or procedures (catheters, sanitary conditions . . .).

But "medical services" is a very specific legal term in P.L. 94-142. Despite common usage of the word " medical," P.L. 94-142 includes only services which are "provided by a licensed physician" [Regulations, 300.13 (b)(4)]. Thus any service which is otherwise a related service, and which is provided by a nonphysician (including therapists, nurses, counselors, psychologists, audiologists . . .), is not a "medical" service under P.L. 94-142 and thus may be an educational responsibility.

It is worth noting that the cause generating the need for such a service may be medical. Bladder problems (catheterization), or motor difficulties (physical therapy) may create the service need. But if that need can be met by nonphysicians, the service (if "educational") will generally be "related" under the law. This result is to be expected. Most handicapping conditions can be described as "medical" in their origin, but the effect, and their amelioration, is often educational, particularly so under a broad concept of education.

It is worth noting too that many services which in the abstract might arguably be "medical" are specifically listed, for P.L. 94-142 definitions, are "related." In addition to those mentioned already (O.T., P.T. . . .), one could add audiology, and school health services.

VI. Summary

It is apparent that the "related services" concept is extremely broad and that it has been expanded, rather than limited, by most judicial interpretations. This result is not entirely attributable to the passage of 94-142. Given an expanded school clientele, judicial concepts of education, and educational opportunity, related services are merely those services inevitably associated with assisting children in reaching basic objectives such as walking, talking, socializing, or otherwise becoming prepared for life.

The judicial impact should not be disregarded. P.L. 94-142 established more extensive federal involvement, funding, and coordination of special education services. But P.L. 94-142 cannot be said to have created rights and obligations which otherwise would not exist. As the legislative history clearly demonstrates, P.L. 94-142 "followed a series of landmark court cases establishing in law the right to an education for all handicapped children." (Reference: #10). It was those cases (Reference: #3, 11) which first solidified an expanded notion of "education" and the inevitable corollary and supplemental services.

Similarly, judicial involvement in the existing context has been expansive. In part because catheterization is so clearly required for regular classroom attendance, while being so easy to administer, the courts have refused to be diverted by technical applications of P.L. 94-142 or the alleged potential of unlimited educational involvement in "medical" or "life support" issues. Nor will the courts

readily allow the child caught in the middle of interagency squabbles over the "educational" or "emotional" origins of his difficulties to go without services (Reference: #8).

VII. Implications

Expanded obligations will inevitably tax existing resources. But as a legal, and perhaps even more importantly, as an eminently practical matter, the efforts to limit "related services" concepts seem peculilarly destined to fail.

It is indesputable that past efforts to access more resources have encountered great difficulty. Cocrdination of diverse service agencies, which often have conflicting priorities, has been especially frustrating. Nevertheless, there are many resources in most communities which might cooperate in providing related services -- under contract and frequently at low cost.

In light of the especially strong impetus to designate the schools as a lead agency, the efforts to minimize legal interpretations of related services run counter to expanding concepts of education entitlement. The better use of precious energy appears to be in optimizing interagency cooperation, developing more efficient systems, reallocating existing funds and resources, and generating additional resources whenever possible. These efforts will be required in any event, and are best commenced now rather than later.

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